CHAPTER 3 - SCHOOL HEALTH SERVICES

REQUIREMENT FOR ENROLLMENT

In order to enroll a child in a Kentucky school, the child must have these on file:

Birth Certificate

KRS 158.032

> (3): Upon enrollment of a student for the first time in any elementary or secondary school, the school shall notify in writing the person enrolling the student that within thirty (30) days the person shall provide either:
>
> (a) A certified copy of the student's birth certificate; or
>
> (b) Other reliable proof of the student's identity and age, and an affidavit of the inability to produce a copy of the birth certificate [(1)]

A matrix of health services has been included (Exhibit 3A) as a referral tool for school entrance requirements that includes the following:

Immunization Certificate

Any child enrolled as a regular attendee in all public or private primary or secondary schools, and preschool programs shall have a current immunization certificate (EPID-230 or EPID-230A) and be on file within two weeks of the child's attendance. (KRS 214.034) [(2)] The child shall have been immunized against diphtheria, tetanus, poliomyelitis, pertussis, measles, rubella, mumps, varicella, hepatitis B, and haemophilis influenzae disease according with testing and immunization schedules established by regulations of the Cabinet for Health Services. (Exhibit 3B-Immunization Certificate)

All public or private primary schools shall require a current immunization certificate for hepatitis B for any child enrolled as a regular attendee in the sixth grade, as provided by administrative regulation of the Cabinet for Health Services, promulgated under KRS Chapter 13A to be on file within two (2) weeks of the child's attendance. This provision shall sunset following the 2008-2009 school year unless otherwise authorized by the General Assembly (KRS 214.034).

Exceptions to testing or immunization requirement: According to KRS 214.036[(3)] there are only two (2) exceptions by which a child may be excused from immunizations.

> (1) Certificate of Medical Exemption. The child's physician must write a statement that the child has a certain specific health/physical conditions, which are, recognized contraindications to the administration of one or more of the required vaccines. The child must then present to the school a medical exemption certificate (EPID-230B). (Exhibit 3C-Medical Exemption)
>
> (2) Certificate of Religious Exemption. The parent must submit a written sworn statement objecting to the immunization of the student on religious grounds. The student must then present to the school a religious exemption certificate (EPID-230C). (Exhibit 3D-Religious Exemption)

Preventive Health Care Exam

704 KAR 4:020 Sec. 2. Preventative Health Care Examinations

> (1) A local board of education shall require a preventative health care examination of each child within one (1) year prior to the child's initial admission to school. A second examination shall be required within (1) year prior to sixth grade, or initial admission to school. A third examination may be required by policy of the local board of education within one (1) year prior to entry into the ninth grade or initial admission to school.
>
> (2) A local school board may extend the deadline not to exceed two (2) months.
>
> (3) An out of state transfer student shall be required to have documentation of a preventative health care examination.

The exam shall be reported on the Preventative Health Care Exam Form, dated December 1999. (Exhibit 3E-Initial Entry; Exhibit 3F-Sixth Grade) The preventative health care examination may be performed and signed for by a physician, and advanced registered nurse practitioner, a physician's assistant, or by a health care provider trained in the early periodic screening diagnosis and treatment programs. [4]

Eye Exam for School Entry

According to KRS 156.160 (10) (g) effective July 15, 2000, the Kentucky Board of Education (KBE) requires a vision examination by an optometrist or ophthalmologist that meets the requirement prescribed by KBE. The law specifically states, "evidence shall be submitted to the school no later than January 1 of the first year that a child is enrolled in public school, public preschool or Head Start program." The optometrist or ophthalmologist performing the examination is to complete and sign the Kentucky Eye Examination Form for School Entry. [5] (Exhibit 3G)

Sports Physicals

KRS 156.070 states "every local board of education shall require an annual medical examination performed and signed by a physician, physician's assistant, advanced registered nurse practitioner or chiropractor, if performed within the professional's scope of practice, for a student seeking eligibility to participate in any high school athletic activity or sport."

According to the Kentucky High School Athletic Association (KHSAA) Bylaw 2. Physician's Certificate and Parent's Consent:

> "The Superintendent or Principal shall have each student who is trying for a place as a participant on an athletic team or cheerleading squad present a physician's certificate certification signed by a physician, physician's assistant, advanced registered nurse practitioner (ARNP), or chiropractor if performed in the scope of practice (as defined in KRS Chapter 312) which shall state that he/she is physically fit to participate without undue risk. The parent's consent for the child's participation and acknowledgement of receipt of the eligibility rules as promulgated by the Association and Kentucky Board of Education regulations in writing shall also be required." (Exhibit 3H)

(Please note that both sides of the athletic physical form must be completed.)

MATRIX OF HEALTH SERVICES

Service	Pre-3	Pre-4	K	1	2	3	4	5	6	7	8	9	10	11	12	Referrals	Transfer Students	Known Problems
Preventative Health Exam	Xm	Xm	Xm						Xm			Xm*					Xm	
Immunization Record	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	
Eye Exam	Xm	Xm	Xm														Xm	
Cumulative Record	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm	Xm		Xm	
Athletic/Sports Physicals++										Xm	Xm	Xm	Xm	Xm	Xm		Xm	
Scoliosis Screening									Xm		Xm							
Vision Screening						Xs		Xs								Xs		Xs
Hearing Screening			Xs	Xs	Xs	Xs										Xs	Xs	Xs
Height & Weight			Xs	Xs	Xs	Xs	Xs	Xs	Xs			Xs						
T.B. Skin Test			R														R	

- Xm-Mandated in 704 KAR 4:020 Section 2: (1) A local board of education shall require a preventative health care exam of each child within one (1) year prior to the child's initial admission to school. A second exam shall be required within one (1) year prior to entry into the sixth grade or initial admission to school. (3) A local school board may exceed the deadline by which to obtain a preventative health care exam no to exceed two (2) months. (9) A valid immunization certificate shall be on file within two (2) weeks of the child's enrollment in school. A preventative health care exam my be performed and signed fo by a physician, and advanced registered nurse practioner, a physician's assistant or a health care provider in the early periodic screening diagnosis and treatment programs.
- **Eye exam:** KRS 165.160: (g) A vision examination by an optometrist or ophthalmologist that shall be submitted to the school no later than January 1 of the first year that a child is enrolled in a public school, public preschool or Head Start
- Xm* 704 KAR 4:020 Section "A third exam may be required by policy of the local school board within 1 year prior to entry into the ninth grade or initial school entry"
- ++ Athletic/Sports Physicals must be given by a Physician, Physician Assistant, Advanced Registered Nurse Practioner or Chiropractor. The exam is valid for one (1) year from the examination date. (KRS 156.070; HSAA Handbook Bylaw 2)
- R- As Recommended. 704 KAR Section 2 (10) TB testing shall be carried out upon notification by a local health department.

- Xs Suggested as appropriate intervals for provision of those services. Scoliosis Screening, Vision Screening, Hearing Screening, Height & Weight: 704 KAR Section 2 (11) A board of education shall adopt a program of continuous health supervision for all school enrollees. Supervision shall include scheduled, appropriate screening tests for vision, hearing and scoliosis. (11) (c) Established scoliosis screening times, at least in grade six (6) and eight (8) and appropriate procedures and referral criteria
- Cumulative Health Records 704 KAR Section 3 (1) A school shall initiate a cumulative health record for each pupil entering its school. The record shall be maintained throughout the pupil's attendance. The record shall include screening tests related to growth and development, vision hearing, and scoliosis and findings and recommendations of a physician and a dentist
- This Matrix of Health Services addresses only the health services required by Kentucky Law or Administrative Regulation. Individual school districts may choose to add additional screenings according to their school district policies.

COMMONWEALTH OF KENTUCKY

IMMUNIZATION CERTIFICATE

(Required of each child enrolled in a public or private school, preschool program, day care center, certified family child care home, or other licensed facility which cares for children.)

Name of Child_____ **Birthdate**_____
(Last) (First) (Middle)

Name of Parent or Guardian_____

Address_____
(Street) (City) (State) (Zip Code)

DATES ADMINISTERED (month/day/year)

DIPHTHERIA, TETANUS, PERTUSSIS* **#1**____/____/____ **#2**____/____/____ **#3**____/____/____ **#4**____/____/____ **#5**____/____/____

POLIO VACCINES **#1**____/____/____ **#2**____/____/____ **#3**____/____/____ **#4**____/____/____

MMR (Measles, Mumps, Rubella)** **#1**____/____/____ **#2**____/____/____ _____ ____/____/____ _____ ____/____/____
Other **Other**

Hib*** **#1**____/____/____ **#2**____/____/____ **#3**____/____/____ **#4**____/____/____

Hepatitis B** **** **#1**____/____/____ **#2**____/____/____ **#3**____/___/___ **or #1**____/____/____ **#2**____/____/____ **(adult dose)**
Varicella *** #1**____/____/____ **or child has had chickenpox disease (X)** _____**.**

*DTaP, DTP, DT, Td **MMR for one dose, measles-containing for second. ***Hib not required at age 5 years or more. **** Alternative two dose series of approved adult hepatitis B vaccine for children 11-15 years of age. *****Varicella required for children 19 months to 7 years unless a parent, guardian or physician states that the child has had chickenpox disease.

This child is current for immunizations until ____/____/____, (two weeks after the next shot is due) after which this certificate is no longer valid and a new certificate must be obtained.

I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE.
Signature of physician, Health Dept., or their designee_____**Date**_____

This Certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record. **EPID-230 (Rev 8/2002)**

COMMONWEALTH OF KENTUCKY

CERTIFICATE OF MEDICAL EXEMPTION

Name of Child_____ **Birthdate**_____
(Last) (First) (Middle)

Name of Parent or Guardian_____

Address_____
(Street) (City) (State) (Zip Code)

MEDICAL EXEMPTION – THE ABOVE NAMED CHILD HAS CERTAIN SPECIFIC HEALTH/PHYSICAL CONDITIONS WHICH ARE RECOGNIZED CONTRAINDICATIONS TO THE ADMINISTRATION OF ONE OR MORE OF THE REQUIRED VACCINES:

VACCINE(S) CONTRAINDICATED_____

DATES ADMINISTERED (month/day/year)

DIPHTHERIA, TETANUS, PERTUSSIS* **#1**____/____/____ **#2**____/____/____ **#3**____/____/____ **#4**____/____/____ **#5**____/____/____

POLIO VACCINES **#1**____/____/____ **#2**____/____/____ **#3**____/____/____ **#4**____/____/____

MMR (Measles, Mumps, Rubella)** **#1**____/____/____ **#2**____/____/____ _____ ____/____/____ _____ ____/____/____
Other **Other**

Hib*** **#1**____/____/____ **#2**____/____/____ **#3**____/____/____ **#4**____/____/____

Hepatitis B** **#1**___/___/___ **#2**___/___/___ **#3**___/___/___ **or #1**___/___/___ **#2**___/__/___ **(adult dose)**
Varicella*** **#1**___/___/___ **or child has had chickenpox disease (X)** _____**.**

*DTaP, DTP, DT, Td **MMR for one dose, measles-containing for second. ***Hib not required at age 5 years or more. **** Alternative two dose series of approved adult hepatitis B vaccine for children 11-15 years of age. *****Varicella required for children 19 months to 7 years unless a parent, guardian or physician states that the child has had chickenpox disease. This child is current for immunizations until ____/____/____, (two weeks after next shot is due) after which this certificate is no longer valid and a new certificate must be obtained.

I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE.
Signature of physician, Health Dept., or their designee_____**Date**_____
This Certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record. **EPID-230B (Rev 8/2002)**

COMMONWEALTH OF KENTUCKY
CHILDHOOD IMMUNIZATION LAW

CERTIFICATE OF RELIGIOUS EXEMPTION

Name of Child_____ Birthdate_____
(Last) (First) (Middle)

Name of Parent or Guardian_____

Address_____
(Street) (City) (State) (Zip Code)

RELIGIOUS EXEMPTION – THE ABOVE NAMED CHILD IS HEREBY GRANTED A RELIGIOUS EXEMPTION OBJECTING TO _____ IMMUNIZATION(S) ON RELIGIOUS GROUNDS. A SWORN STATEMENT FROM THE PARENT OR GUARDIAN IS ATTACHED.

_____ _____
(Signature of physician, health dept., or their designee) **(Date)**

_____
(Address)

This Certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record.

EPID-230C (Rev 09/2002)

December 1999

PREVENTATIVE HEALTH CARE EXAMINATION FORM - INITIAL ENTRY [headstart - fourth (4) grade]

All local boards of education shall require a preventative health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school. Local school boards may extend this time not to exceed two (2) months. The administration shall have an approved program of continuous health supervision which shall include evidence of having been screened for vision and hearing.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____

Social Security Number: _____ **Date of Birth:** _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.

MEDICAL HISTORY

Seizures: _____

Chronic Illness: _____

Allergies: _____

Medications: _____

Significant Historical Information: _____

_____

Physical Exam:

N.	Abn.		
_____	_____	General Appearance	Hgt:_____ Wgt:_____ BP:_____/_____
_____	_____	HEENT	Hearing: R_____ L_____
_____	_____	Skin	Vision: R_____/ _____ L _____/_____
_____	_____	Neck	STRABISMUS/AMBLYOPIA SCREEN ☐ ABNORMAL
_____	_____	Chest	Optional---------HCT/HGB: _____(required for headstart)
_____	_____	Heart	Optional----------UA: _____
_____	_____	Abd - Genitalia	
_____	_____	Extremities-Back	
_____	_____	Neuro	

Explain Abnormal Exam: _____

_____

Recommendations:

_____ **No Restrictions: Normal Exam**

_____ **RESTRICTIONS AND SUGGESTIONS TO SCHOOL:** _____

_____

_____

Age appropriate and suggested anticipatory guidance *(health assessments)*

☐ **Discuss injury prevention with parents**

☐ **Bicycle Safety** ☐ **Car Seat Belts** ☐ **Memorization of Name, Address and Phone Number**

☐ **Advise the child not to go with or accept anything from strangers and feel free to say "NO" to strangers.**

☐ **Emphasize the importance of dental care.**

☐ **Discuss mental health issues.**

Signed: _____ **Date:** _____

Physician/ARNP/PA/EPSDT Provider

Address: _____ **Telephone:** _____

Kentucky Department of Education

PREVENTATIVE HEALTH CARE EXAMINATION FORM - Sixth (6th) Grade Form (for grades 5-12)

All local boards of education shall require a second and third preventative health care examination of each child within one (1) year prior to entry into the sixth (6th) grade or subsequent grades. Each board shall have an approved program of continuous health supervision in accordance with current statutes and regulations, vision, hearing and scoliosis scheduled screening tests. Local school districts shall establish a plan for implementation and compliance with the sixth (6th) grade examination.
PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION Grade: 5th 6th 7th 8th 9th 10th 11th 12th *(Circle appropriate grade)*

Student Name: _____

Social Security Number: _____ **Date of Birth:** _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230.

MEDICAL HISTORY

Seizures: _____

Chronic Illness: _____

Allergies: _____

Medications: _____

Significant Historical Information _____

_____

Physical Exam:

N.	Abn.		
_____	_____	General Appearance	Hgt:_____ Wgt:_____ BP: _____ / _____
_____	_____	HEENT	Hearing: R _____ L _____
_____	_____	Skin	Vision: R_____/ _____ L _____/_____
_____	_____	Neck	Optional---------HCT/HGB: _____
_____	_____	Chest	Optional----------UA: _____
_____	_____	Heart	
_____	_____	Abd-Genitalia	
_____	_____	Extremities-Back (including scoliosis screen for 6th grade)	
_____	_____	Neuro	

Explain Abnormal Exam: _____

_____

Recommendations:

_____ **No Restrictions: Normal Exam**

_____ **RESTRICTIONS AND SUGGESTIONS TO SCHOOL:** _____

_____

_____

Age Appropriate and Suggested Anticipatory Guidance *(Health Assessments)*

1. **How have things been going for you at school? With your peers?**
2. **How do you rate your own health?**
3. **What concerns do you have about your own development?**

Advise adolescents about the following good health habits and self-care. – See sample reference on back of form.

☐ **Risk behaviors were discussed and addressed**

☐ **Risk behaviors were not addressed today**

Signed: _____ **Date** _____
Physician/ARNP/PA/EPSDT Provider

Address: _____ **Telephone:** _____

Guidelines Only - Please do not mark risk factors on this form.

	Low Risk	**Moderate Risk**	**High Risk**
Body Mass Index	Between 15-85% Normal weight/ height per the growth chart	Between 5-15%/85-95% (Just over or just under the normal range)	<5%/>95% (Much over or much under normal weight)
Weight perception	Feels good about weight	Feels "fat" even though weight is normal on the chart	Skips meals, vomits, takes medicine, or exercises too much to control weight
Nutrition	Eats 3 meals/day; and eats fruits, vegetables, and foods with fiber	Eats less than 3 meals/day; or vegetarian without milk or eggs	Eats a lot of snacks with fat and sugar, eats few regular meals
Exercise	5 times/week for at least 20 min each, with increased heart rate and sweating	Exercises less than 5 times/week, not strenuously	No regular exercise to increase heart rate
Tobacco use	No smoke or chew	Smoke or chew less than daily; or Stopped less than 6 weeks ago	Smoke or chew regularly
Drug use	Never used	Previously used; not in the past 3 months	Recently used or currently uses marijuana, huffing, LSD, cocaine, heroin, etc.
Alcohol use	Has only tasted it, or used for religious purpose	Social only, not more than once/week; less than 3 beers or 2 liquor drinks at a time	Drunkenness, blackouts; drinking interferes w/school, family, etc.; 4 or more drinks at a time
Sexual activity	Never, or is married and faithful	Not in last 6 months; safe sex with condoms	Sex without regular use of condoms; first intercourse before age 16
School	B/C average or better, steady improvement in grades	Grades slipping; detention problem	Failing grades; suspension; often skips school
Depression	Usually happy	Often feels discouraged or down; cries a lot	Unhappy most of the time; feels hopeless; thought of suicide
Abuse	No physical or sexual abuse	Abuse reported and counseling received	Abuse still occurring or not treated with counseling
Safety	Uses seat belt/helmet, never rides with drunk driver	Usually uses seat belt/helmet; rarely rides with drunk driver	Does not use seat belt/helmet; has driven drink; sometimes rides with drunk driver
Violence	No fights, no threats, does not carry a knife, gun, or rifle, no legal troubles	Threatens others; previous illegal acts (stealing, etc.) but not in past 3 months	Damages own or others' property; carries a gun, knife, or rifle; physical fights with peers; has had contact with police
Family relationships and responsibility	Gets along with family, completes chores or work duties	Often argues with family; does not complete chores or work duties	Physical and/or intense verbal fights with family
Friends and Recreation	Has male and female friends; involved in clubs, activities, or hobbies	Has few friends; does things alone; has friends who often get into trouble	Has no friends; or belongs to gang or cult
Good qualities and Future plans	Can name 3 good qualities about self; has plans for the future	Hard to think of good qualities about self; has few interests; does not have future	No good qualities about self; no interests or activities
Immunizations	Second MMR; tetanus within ten years; hepatitis series; had varicella or been vaccinated	Lacks any one item	Lacks two or more items

Kentucky Eye Examination Form for School Entry

8/2000

KRS 156.160 (1) (g) requires proof of a vision examination by an optometrist or ophthalmologist. This evidence shall be submitted to the school no later than January 1 of the first year that a three (3), four (4), five (5) or six (6) year old child is enrolled in public school, public preschool, or Head Start program.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____

Date of Birth: _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATION TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230

CASE HISTORY

Date of Exam: _____

Ocular History: Normal ☐ or Positive for: _____

Medical History: Normal ☐ or Positive for: _____

Drug Allergies: NKDA ☐ or Allergic to: _____

Family Ocular and Medical History: ☐ Amblyopia ☐ Strabismus ☐ Glaucoma ☐ Diabetes
Other: _____

Other Pertinent Information: _____

Refraction with cycloplegic? (please indicate one) ☐ YES ☐ NO

	OD	OS
Unaided Acuity	20 / _____	20 / _____
Best Corrected Acuity	20 / _____	20 / _____

	Normal	Abnormal	Not able to Assess
External Exam (eye and adnexa)	☐	☐	☐
Internal Exam (media, lens, fundus, etc)	☐	☐	☐
Neurological Integrity (pupils)	☐	☐	☐
Binocular Function (stereopsis)	☐	☐	☐
Accommodation and convergence	☐	☐	☐
Color Vision	☐	☐	☐

Diagnosis: ☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other: _____

Recommendations:

1 Glasses prescribed: ☐ YES ☐ NO

2 _____

3 _____

Age appropriate and suggested anticipatory guidance (health assessments):

- ☐ Educate (parents/patients) about eye/vision disorders and needed vision care
- ☐ Counsel (parents/patients) regarding eye safety
- ☐ Stress importance of early, preventative eye care
- ☐ Recommend re-examination, as appropriate

Signed: _____ Date: _____
Optometrist/Ophthalmologist

Address: _____ Telephone: ( ) _____

3G

KENTUCKY HIGH SCHOOL ATHLETIC ASSOCIATION

2280 Executive Drive, Lexington, Kentucky 40505

Athletic Participation/Parental Consent/Physical Examination Form

PART I - ATHLETE INFORMATION

(To be completed by athlete)

Name: _____ School Year _____

(Last) (First) (Initial)

Home Address: _____

(Street) (City, State, zip)

Date of Birth: _____ Birth Place (County, State): _____

This is my _____ year at _____ School and my _____year since entering ninth grade. Last year I attended _____

School. I am planning to participate in the following (circle all you might try to play):

Baseball	Cross Country	Golf	Softball	Tennis	Vollevball
Basketball	Football	Soccer	Swimming	Track	Wrestling
Cheerleading	Field Hockey	Other:			

PART II - MEDICAL HISTORY

This form must be completed by parent and athlete prior to the time of the physical exam and presented to the authorized health care provider before the physical.

CHECK THE APPROPRIATE RESPONSE TO EACH ITEM:	YES	NO
1. Have you ever been hospitalized?	❒	❒
Have you ever had surgery of any kind (e.g., tonsillectomy).	❒	❒
2. Are you presently taking any medications or pills?	❒	❒
3. Do you have any allergies (medicine, bees, or other insects)?.	❒	❒
4. Have you ever passed out during exercise?	❒	❒
Have you ever been dizzy during or after exercise?	❒	❒
Have you ever had chest pain during or after exercise?	❒	❒
Have you ever had high blood pressure?	❒	❒
Have you ever been told you have a heart murmur?	❒	❒
Have you ever had racing of your heart?	❒	❒
Has anyone in your family died of heart problems before 50?.	❒	❒
5. Do you have any skin problems? (itching, rashes, acne)	❒	❒
6. Have you ever had a head injury?	❒	❒
Have you ever been knocked out or unconscious?	❒	❒
Have you ever had a seizure or suffer from epilepsy?	❒	❒
Have you ever had a stinger, burner or pinched nerve?	❒	❒
7. Have you ever had heat related problems?	❒	❒
Have you ever been dizzy or passed out in the heat?.	❒	❒
8. Do you cough heavily, or breath heavily during activity?	❒	❒
9. Do you use any special equipment (e.g., knee brace)?	❒	❒
10. Have you had any problems with your eyes or vision?.	❒	❒
11. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones?	❒	❒
12. Are you missing one of any paired organs (e.g., eyes)	❒	❒
13. Have you ever been diagnosed with any form of asthma?	❒	❒
Are you using an inhaler for asthma?	❒	❒
14. Are you diabetic?	❒	❒
Do you administer insulin to yourself?	❒	❒
15. Are you presently using tobacco in any form?	❒	❒
16. Do you have a history of sickle-cell anemia in your family?	❒	❒
17. Have you had any other medical problems?	❒	❒
18. Have you had a medical problem or injury within the last year?	❒	❒
19. Can you swim?	❒	❒

20. When was your last tetanus shot?_____

Please explain any YES answers from questions 1-18. _____

_____

_____

PART III - PHYSICAL EXAMINATION

NAME: _____ SEX _____

SCHOOL: _____ GRADE _____

HEIGHT: _____ WEIGHT _____ BP _____ / _____ PULSE _____

VISION: R- 20/ ____ L- 20/ ____ BOTH- 20/ ____ CORRECTED? Y N

	Normal	Abnormal	Comment
HEART			
Rhythm (Regular/Irregular)			
Murmur (supine)			
Murmur (standing)			
ENT			
Lungs			
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulder			
Elbow			
Wrist			
Hand			
Back			
Knee			
Ankle			
Foot			
Dental			
Other			

I have reviewed the data above, reviewed the student's medical history and make the following recommendations on participation in athletics:

1. Cleared _____
2. Cleared after additional evaluation for _____
3. Restricted from participating in the sports of _____
4. Cleared to participate in the sports of _____

Recommendations/Restriction _____

_____

_____

In accordance with KHSAA Bylaws, I have examined the physical condition of the student and find the said pupil to be physically fit to practice for and participate in interscholastic athletic contests.

_____

Authorized Signature Date

_____

Authorized Provider's Name (please print)

_____

Address Phone

_____

Date City, State, Zip

PART IV - ACKNOWLEDGMENT OF RISK, STATEMENT OF HAZARDS IN PARTICIPATION IN ATHLETICS AND PARENTAL CONSENT

The student athlete and the parent/guardian should read this statement carefully. You should be aware that playing or practicing to play or helping with or participating in any manner in any sport can be a dangerous activity involving many risks of injury. The dangers and risks of playing, practicing to play, helping or participating in sports include, but are not limited to, death, serious neck, head and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular skeletal system, and serious injury or impairment to other aspects of the body, general health and well being. Because of the dangers of participating in sports, the student should recognize the importance of following the coaches' instructions regarding playing techniques, training and other team rules and obey such instruction.

In accordance with the purpose and spirit of KHSAA Bylaws, I acknowledge receipt of the included eligibility rules as put forth by the KHSAA and Kentucky Board of Education and understand additional rules may apply to my child. I also am aware of the risk of a wide range of injuries to my child as a result of participation in sports, with contact sports having a higher risk.

In accordance with the purpose and spirit of Kentucky High School Athletic Association Bylaws, Physician's Certificate and Parental Consent, I acknowledge receipt of the the current year's eligibility rules as promulgated by the Association and Kentucky Board of Education regulations. I understand that my child must have insurance coverage up to a limit of $25,000 in order to be eligible to try for a place on an athletic team with the company listed below. I give consent for my son/daughter to represent his/her high school in interscholastic athletic contests for one calendar year from the date of this physical examination in the sport(s) checked below:

He/she is planning to participate in the following (circle all you might try to play):

Baseball	Cross Country	Golf	Softball	Tennis	Volleyball
Basketball	Football	Soccer	Swimming	Track	Wrestling
Cheerleading	Other: _____				

I also give my consent and approval for this student-athlete to receive a physical examination, as required by the KHSAA and acknowledge the risks inherent with participation.

Please complete both sides of this form, detach it from the Eligibility Rules and Regulations, and return it to the Principal of your high school immediately. I understand this **must** be done before my child practices or participates in any one of the above listed sports. I also understand the personal safety of the student is of first importance to the school. In event of needed professional medical care, I give my permission for a representative of the school to transport my child to the nearest medical facility and for staff of that facility to render treatment.

(To be completed and signed by parent/guardian)

_____

Signature of Parent/Guardian Date

_____

Student's Name

_____

High School

_____

Parent's Name (please print)

_____

Address

_____

Phone No.

_____

Insurance Carrier

_____

Insurance Policy Number

Students desiring to participate in Wrestling must also complete KHSAA Form WR101 and required attachments between October 15 and December 15.

PART V. ATHLETES' ACKNOWLEDGMENT OF RISK AND PARTICIPATION

As an athlete I recognize the importance of following coaches instructions regarding playing techniques, training and other team rules, etc., and agree to obey such instruction in order to be sate and try to avoid injury. I also give school representatives permission to release my demographic information and playing or participation statistics and other information as may be requested, and agree that I may be photographed or otherwise captured during competition and such image may be used without my permission.

_____

Signature of Athlete

PART VI - EMERGENCY PERMISSION FORM

(To be completed by parent / guardian)

STUDENT NAME _____

SOC. SEC. NO _____

ADDRESS _____

_____

CITY/STATE/ZIP _____

SCHOOL _____

BIRTH DATE _____

PHONE _____

PERSON TO CONTACT IN CASE OF MEDICAL EMERGENCY:

NAME _____

RELATION _____

ADDRESS _____

CITY/STATE/ZIP _____

DAYTIME PHONE _____

EVENING PHONE _____

Please list any health problems/concerns your child may have, including allergies (medications / others) and any medications presently being used: _____

_____

In the event that an athletic injury should occur to the above named student-athlete I give my permission for them to receive proper/necessary care from a certified athletic trainer or coach employed by or representing _____ School.

Furthermore, in the event that a medical emergency should occur and I cannot be contacted I give my permission for a school representative (coach, athletic trainer) to arrange for ambulance service to the nearest medical facility. I also give permission for the staff of the medical facility to render treatment which is considered necessary for the student-athletes well being.

_____

Parent/Guardian Signature:

Date: _____

Emergency permission form must be reproduced to travel with respective athlete and is acceptable for emergency treatment.
Physical Exam Valid for One Year from Date Administered.
Physical Exam must be signed by authorized Health Care Providers named in Bylaw 2.